STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50A260	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fircrest Nursing Facility	15230-15th Northeast Seattle, WA 98155

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate supervision for 1 of 3 residents (Resident 1), reviewed for accident hazards. This failure placed the resident at risk for serious harm and injury, and a diminished quality of life.Findings included.Review of the facility policy titled, Detection and Prevention of Abuse, Neglect and Financial Exploitation, revised on January 2024, showed [name of facility]'s highest priority is to maintain the safety and well-being of all clients [residents].Resident 1 was admitted to the facility on [DATE] with diagnosis that included profound intellectual disabilities (severe learning disabilities requiring extensive support and care in all areas of daily life).Review of the annual Minimum Data Set (an assessment tool) dated 07/25/2025 showed Resident 1 had severe cognitive impairment and required total care with activities of daily living.Review of Resident 1's comprehensive care plan printed on 08/14/2025 showed an intervention to provide 1:1 [one on one] protective supervision, AM [morning] and PM [evening]. Further review of the care plan showed Resident 1 had self-injurious (deliberately harming one's body) behavior and pica (abnormal desire to eat substances not normally considered food).Review of the facility's investigation report dated 07/17/2025, showed Staff C, Certified Nurse Assistant (CNA) had been assigned to provide 1:1 protective supervision to Resident 1. Further review of the investigation report showed Staff B, Attendance Counselor Manager was notified of Resident 1's absence from lunch and went to check Resident 1 in their room and Staff B found Resident 1 asleep in their wheelchair and observed Staff C sitting on a chair asleep as well. Further review showed Staff B called out Staff C's name three times to wake them up.In an interview on 08/14/2025 at 11:22 AM, Staff B stated that they were notified by Staff D, CNA, that Resident 1 was not in the dining room for their lunch meal. Staff B stated that they went to look for Resident 1 and found the privacy curtain drawn closed all the way in Resident 1's room area. Staff B stated that they peeked through the curtain and saw Resident 1 asleep in their wheelchair and saw Staff C asleep on a chair. Staff B stated that they called out Staff C's named three times to wake them up. Staff B further stated that Staff C was expected to pay close attention to Resident 1 and to monitor their behavior.In an interview and joint record review on 08/14/2025 at 12:01 PM, Staff E, Registered Nurse 2 stated that staff assigned to resident requiring 1:1 was expected to monitor them all the time. Their [staff] eyes should always be on them. A joint record review of Resident 1's behavior care plan showed Resident 1 had self-injurious behavior and pica and needed 1:1 protective supervision. Staff E stated that Staff C did not pay close attention because [Staff C] was sleeping.In an interview on 08/20/2025 at 1:39 PM, Staff A, Director of Nursing, stated that they expected staff to follow according to the individual care plan and to be alert, awake, [and] not sleeping when assigned 1:1 with the resident. Staff A further stated that Staff C did not provide protective supervision to Resident 1.Reference: (WAC) 388-97-1060 (3)(g).

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure baseline care plan (initial instructions on necessary care until a comprehensive care plan is established) was accurate for 1 of 3 residents (Resident 2), reviewed for resident records. This failure placed the resident at risk for unmet care needs and a diminished quality of care.Findings included.Review of a face sheet printed on 08/14/2025 showed Resident 2 was admitted to the facility on [DATE] for respite care (short-term care).Review of a baseline care plan printed on 08/14/2025 showed Resident 2's Recreation (Activity) care plan had another resident's name in it. Further review of the baseline care plan showed, [other person's name] requires colostomy [a surgical opening for the large intestine through the abdomen for stool elimination] care. had been included in Resident 2's self-care deficit care plan.Review of the physician's progress note dated 07/24/2025 did not show Resident 1 had a colostomy.In an interview and joint record review on 08/20/2025 at 1:17 PM, Staff F, Registered Nurse 2, stated they formulated Resident 2's baseline care plan. Staff F stated that the baseline care plan was part of Resident 2's medical records and must be accurate. A joint record review of Resident 2's recreation care plan showed a name different from Resident 2's name. Staff F stated the recreation care plan had another person's name in it and that it was an error. A joint record review of Resident 2's self-care deficit care plan showed another person's name that included colostomy care. Staff F stated that Resident 2 had no colostomy and that it was inaccurate information. Staff F stated that they expected Resident 2's baseline care plan to be accurate.In an interview and joint record review on 08/20/2025 at 1:32 PM, Staff A, Director of Nursing, stated that a resident's care plan must reflect their clinical status. Staff A stated that the care plan was part of a resident's medical records and must be accurate. A joint record review of Resident 2's recreation and self-care deficit baseline care plan showed other persons' names and the self- care deficit care plan had colostomy care. Staff A stated that Resident 2's care plan had inaccurate information and that they expected accuracy with their medical records.Reference: (WAC) 388-97-1720 (1)(a)(i)(ii).